Letter of Appeal
Rural Health Care Division
Universal Service Administrative Company
2000 L Street, N.W., Suite 200
Washington, D.C. 20036

Appellant/Health Care Provider:	Bristol Bay Area Health Corporation 6000 Kanakanak Road Dillingham, AK 99576 (907) 842-5201 HCP No. (see Table 1 below)
Service Provider Name:	GCI Communication Corp. SPIN 143001199
Form 465 Number:	(see Table 1 Below)
Funding Request Number:	(see Table 1 Below)

Dear Rural Health Care Division Staff:

Bristol Bay Area Health Corporation (BBAHC) provides health care services to Alaska Natives and other beneficiaries on behalf of tribal governments and Native Villages in the Bristol Bay region pursuant to the Alaska Tribal Health Compact and funding agreements with the Secretary of Health and Human Services under the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 et seq. BBAHC hereby requests review and reversal of the decision of the Rural Health Care (RHC) Division to deny funding for the above-referenced Funding Requests for services provided by GCI.[1]

BBAHC believes that the RHC Division erred in concluding that it would arbitrarily apply an across-the-board pro rata reduction in funding due to the $400 million funding cap that the Federal Communications Commission (FCC) purported to impose, thus eliminating any opportunity for full funding for the services requested in its Forms 465 and Form 466. Therefore, BBAHC believes that it has met all requirements of the RHC funding mechanism, and that the RHC Division should have committed funding for the Funding Requests summarized in the attached table.

Background

The BBAHC Form(s) 465 referenced in the below Table 1 were submitted on behalf of BBAHC for services at clinics that provide health care for BBAHC member tribes' populations as well as other eligible beneficiaries.

[1] RHC Division Funding Commitment Letters dated April 11, 2017 attached as **Exhibit A.**

On April 11, 2017, 55 Funding Commitment Letters (FCLs) were issued by USAC. In those FCLs, USAC for the first time distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The asterisk used by USAC then stated the following: "The pro-rata factor for this filing window period is 92.52804%."

USAC remitted funding to BBAHC through the FCLs at the rate of 92.52804% of the amount requested, resulting in the denial of funding for the FCLs in the amount of $1,757,574.99. The application of a pro rata percentage of funding by USAC amounted to a partial denial of funding, even though the FCL is not written by USAC as a funding denial.

BBAHC believes that its funding request and the total funding amount approved by USAC comply with applicable law and the FCC's requirements, but that the arbitrarily created category of "Committed Funding" based upon a pro rata formula is contrary to applicable law and policy. Therefore, BBAHC respectfully requests that the RHC Division reverse its decision and issue full funding for these funding requests.

Requested and Disputed Funding

The table below lays out in detail the Service Provider, Health Care Provider, Form 465 Application Numbers, Funding Request Numbers, total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the pro rata formula.

Table 1

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI - 143001199	Chignik Lake Clinic 10973	43162386	16881531	$157,657.35	$145,877.26	$11,780.09
GCI - 143001199	Chignik Lake Clinic 10973	43162386	16885661	$89,159.66	$82,497.69	$6,661.97
GCI - 143001199	Chignik Lake Clinic 10973	43162386	16901981	$638,750.39	$591,023.22	$47,727.17
GCI - 143001199	Clarks Point Health Clinic 10974	43162387	16885711	$1,202.21	$1,112.38	$89.83
GCI - 143001199	Clarks Point Health Clinic	43162387	16902691	$7,841.16	$7,255.27	$585.89

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
	10974					
GCI - 143001199	Naknek Clinic 10975	43162388	16885721	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Naknek Clinic 10975	43162388	16902701	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	New Stuyahok Clinic 10976	43162389	16885741	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	New Stuyahok Clinic 10976	43162389	16902741	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Perryville Clinic 10980	43162390	16885761	$157,657.35	$145,877.26	$11,780.09
GCI - 143001199	Perryville Clinic 10980	43162390	16885771	$89,159.66	$82,497.69	$6,661.97
GCI - 143001199	Perryville Clinic 10980	43162390	16902791	$638,750.39	$591,023.22	$47,727.17
GCI - 143001199	Aleknagik Health Clinic 10981	43162391	16885801	$1,202.21	$1,112.38	$89.83
GCI - 143001199	Aleknagik Health Clinic 10981	43162391	16902821	$7,841.16	$7,255.27	$585.89
GCI - 143001199	Chignik Bay Subregional Clinic 10982	43162392	16885811	$159,459.26	$147,544.53	$11,914.73
GCI - 143001199	Chignik Bay Subregional Clinic 10982	43162392	16885821	$90,178.69	$83,440.57	$6,738.12
GCI – 143001199	Chignik Bay	43162392	16902841	$632,265.22	$585,022.62	$47,242.60

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
	Subregional Clinic 10982					
GCI - 143001199	Chignik Lagoon Clinic 10983	43162393	16885831	$159,459.26	$147,544.53	$11,914.73
GCI – 143001199	Chignik Lagoon Clinic 10983	43162393	16885851	$90,178.69	$83,440.57	$6,738.12
GCI - 143001199	Chignik Lagoon Clinic 10983	43162393	16902861	$632,265.22	$585,022.62	$47,242.60
GCI - 143001199	King Salmon Health Clinic 10989	43162394	16885911	$195,202.28	$180,616.84	$14,585.44
GCI - 143001199	King Salmon Health Clinic 10989	43162394	16903001	$576,375.80	$533,309.23	$43,066.57
GCI - 143001199	Platinum Clinic 10990	43162395	16885941	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Platinum Clinic 10990	43162395	16902871	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Port Heiden Clinic 10991	43162396	16886031	$159,459.26	$147,544.53	$11,914.73
GCI - 143001199	Port Heiden Clinic 10991	43162396	16886061	$90,178.69	$83,440.57	$6,738.12
GCI - 143001199	Port Heiden Clinic 10991	43162396	16902901	$632,265.22	$585,022.62	$47,242.60
GCI -	Kanakanak	43162397	16886131	$81,759.61	$75,650.56	$6,109.05

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
143001199	Hospital 10992					
GCI - 143001199	Kanakanak Hospital 10992	43162397	16886201	$1,077,512.77	$997,001.45	$80,511.32
GCI - 143001199	Kanakanak Hospital 10992	43162397	16886241	$47,382.00	$43,841.64	$3,540.36
GCI - 143001199	Kanakanak Hospital 10992	43162397	16903921	$4,014,912.31	$3,714,919.67	$299,992.64
GCI - 143001199	Kanakanak Hospital 10992	43162397	16903961	$1,076,895.00	$996,429.84	$80,465.16
GCI - 143001199	Pilot Point Clinic 10993	43162398	16886381	$159,459.26	$147,544.53	$11,914.73
GCI - 143001199	Pilot Point Clinic 10993	43162398	16886411	$90,178.69	$83,440.57	$6,738.12
GCI - 143001199	Pilot Point Clinic 10993	43162398	16902931	$632,265.22	$585,022.62	$47,242.60
GCI - 143001199	Egegik Clinic 10994	43162399	16886451	$157,657.35	$145,877.26	$11,780.09
GCI - 143001199	Egegik Clinic 10994	43162399	16886491	$89,159.66	$82,497.69	$6,661.97
GCI - 143001199	Egegik Clinic 10994	43162399	16903021	$638,750.39	$591,023.22	$47,727.17
GCI - 143001199	Ekwok Health Clinic 10995	43162420	16886531	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Ekwok Health Clinic 10995	43162420	16903041	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Levelock Health Clinic 10996	43162421	16886541	$60,039.68	$55,553.54	$4,486.14

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI - 143001199	Levelock Health Clinic 10996	43162421	16903081	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	South Naknek Clinic 10998	43162422	16886551	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	South Naknek Clinic 10998	43162422	16903091	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Twin Hills Clinic 10999	43162423	16886561	$158,153.34	$146,336.19	$11,817.15
GCI - 143001199	Twin Hills Clinic 10999	43162423	16903101	$783,679.83	$725,123.59	$58,556.24
GCI - 143001199	Manokotak Clinic 11005	43162424	16886571	$1,387.16	$1,283.51	$103.65
GCI - 143001199	Manokotak Clinic 11005	43162424	16903111	$7,373.03	$6,822.12	$550.91
GCI - 143001199	Goodnews Bay Clinic 11007	43162425	16886581	$60,039.68	$55,553.54	$4,486.14
GCI - 143001199	Goodnews Bay Clinic 11007	43162425	16903151	$982,568.22	$909,151.12	$73,417.10
GCI - 143001199	Togiak Subregional Clinic 11008	43162426	16886591	$142,045.07	$131,431.52	$10,613.55
GCI - 143001199	Togiak Subregional Clinic 11008	43162426	16903171	$816,333.27	$755,337.17	$60,996.10
GCI - 143001199	Koliganek Clinic 11009	43162427	16886601	$60,039.68	$55,553.54	$4,486.14
GCI -	Koliganek	43162427	16903181	$982,568.22	$909,151.12	$73,417.10

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
143001199	Clinic 11009					
					Total:	**$1,757,574.99**

Discussion

The BBAHC is not merely an interest group, community health program, or loose assemblage of health care providers in rural Alaska. BBAHC is a regional organization formed by sovereign Alaska Native nations, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by BBAHC in the Bristol Bay region is not simply a goal to hopefully be obtained but is rather a part of the federal trust responsibility to tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what has become known as "federal Indian law," including the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.*

The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" took different forms and doctrines. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care with the Indian Health Care Improvement Act, where the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting

responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to tribes and Alaska Native villages that the FCC's approach to rural health care must be understood. The FCC took up the matter of its own relationship with tribes/Alaska Natives in June 2000 with its Policy Statement "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes." In that Policy Statement, the FCC states that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

Among other ways that the FCC has specifically committed itself to implementing the trust responsibility, the FCC states that it will "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives ... that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* In addition, the FCC "[w]ill endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

The BBAHC has entered into multiple agreements with the federal government under the Indian Self-Determination and Education Assistance Act (ISDEAA) in order to contract/compact for funding to carry out health care programs, functions, services and activities. Health care is one such area where BBAHC, and its member tribes and villages, fundamentally rely upon RHC funding through the USAC to carry out federal programs and the federal trust responsibilities. Therefore, BBAHC relies upon the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between BBAHC and the United States.

Section 254(h)(1)(A) of the Telecommunications Act is written unambiguously as a mandatory program that includes funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress instructed the FCC to make payments to telecommunications providers on behalf of rural health care providers and a "[t]elecommunications carrier providing service under this paragraph **shall be entitled** to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its **obligation** to participate in the mechanisms to

preserve and advance universal service." (emphasis added) 47 U.S.C. § 254(h)(1)(A). Like the federal trust responsibility, these payments by the FCC, through the USAC, are mandatory, not optional. The FCC and the USAC may not ignore the mandatory language of the statute by invoking a non-statutory cap on payments.[2]

If the RHC has a question with how to interpret the meaning of "shall be entitled" and "obligation", it should note that the Commission has, in the past, interpreted other terms in question in favor of federally recognized tribes "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes" such as the BBAHC's member tribes. *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003).

Following the passage of the Telecomm Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No. 96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, but involved the right to federal funding:

> Section 254(h)(1)(A) grants the **right to receive** federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state." *FCC Universal Service Order* at 335-36 (emphasis added).

But instead of then structuring the program at the outset as a program with mandatory funding obligations that sprang from the statute itself, the FCC made the determination to establish a $400 million cap on RHC funding. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

FCC lacked the authority, under the statute, to create this arbitrary cap. The legality of the cap has not yet been litigated because the funding within the so-called cap has, until 2016, kept pace with demand for funding. This is notwithstanding the fact that if the initial $400 million cap had been increased in pace with inflation, it should now (at a minimum) be funded at $609,405,607. Nonetheless, the FCC has kept the cap in place, despite the mandate of the statute.

Even when it established the cap, the FCC still intended the RHC to provide full funding. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a

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[2] *Cf. Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the caps were statutory, and full payment was still required. Here, the caps are merely unpromulgated agency guidelines.

specific amount to Congress, not to require a pro rata formula for distribution. The FCC stated "[w]e estimate that the **maximum** cost of providing services eligible for support under section 254(h)(1)(A) is $366 million, if **all eligible health care providers** obtain the **maximum** amount of supported services to which they are **entitled**." *FCC Universal Service Order* at 366 (emphasis added).

Funding for broadband-enabled health care is needed today more than ever, and the $400 million cap established 20 years ago was not established consistent with the statutory language mandating full RHC funding. The USAC now administers almost $10 billion annually in the Universal Service Fund.[3] The FCC cap, in shorting tribes and Alaska Native organizations such as BBAHC, has violated the agency's own tribal Policy Statement as well as the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. 2016 has shown that this arbitrary cap is now not only no longer sufficient to meet burgeoning demand, but the inclusion of a new class of provider eligible to receive funding – skilled nursing facilities – beginning in 2017 will place additional demands on funding and further erode BBAHC programs and services. Lives are truly at stake.

Conclusion

Therefore, for the foregoing reasons, BBAHC requests that this appeal be granted and that the RHC Division commit full funding for all of the attached FCLs in the amount that is in dispute due to the pro rata formula $1,757,574.99.

Respectfully Submitted,

Geoffrey D. Strommer by SDO

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On behalf of
Bristol Bay Area Health Corporation

[3] http://www.usac.org/about/default.aspx.

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Appellant/Health Care Provider:	Maniilaq Association P.O. Box 256 Kotzebue, AK 99752 Tel: 907-442-3311 HCP No. (see Table 1 below)
Service Provider Name:	GCI Communication Corp. SPIN: 143001199
Form 465 Number:	(see Table 1 Below)
Funding Request Number:	(see Table 1 Below)

Dear Rural Health Care Division Staff:

The Maniilaq Association (Maniilaq) provides health care services to Alaska Natives and other beneficiaries on behalf of 12 federally recognized tribal governments pursuant to the Alaska Tribal Health Compact and funding agreements with the Secretary of Health and Human Services under the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 et seq. Maniilaq hereby requests review and reversal of the decision of the Rural Health Care (RHC) Division to deny funding for the above-referenced Funding Requests for services provided by GCI.[1]

Maniilaq believes that the RHC Division erred in concluding that it would arbitrarily apply an across-the-board pro rata reduction in funding due to the $400 million funding cap that the Federal Communications Commission (FCC) purported to impose, thus eliminating any opportunity for full funding for the services requested in its Forms 465 and Form 466. Therefore, Maniilaq believes that it has met all requirements of the RHC funding mechanism, and that the RHC Division should have committed funding for the Funding Requests summarized in the attached table.

Background

The Maniilaq Form(s) 465 referenced in the below Table 1 were submitted on behalf of Maniilaq for services at clinics that provide health care for Maniilaq member tribes' populations as well as other eligible beneficiaries.

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[1] RHC Division Funding Commitment Letters dated April 11, 2017 attached as **Exhibit A.**

On April 11, 2017, 16 Funding Commitment Letters (FCLs) were issued by USAC. In those FCLs, USAC for the first time distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The asterisk used by USAC then stated the following: "The pro-rata factor for this filing window period is 92.52804%."

USAC remitted funding to Maniilaq through the FCLs at the rate of 92.52804% of the amount requested, resulting in the denial of funding for the FCLs in the amount of $203,643.34. The application of a pro rata percentage of funding by USAC amounted to a partial denial of funding, even though the FCL is not written by USAC as a funding denial.

Maniilaq believes that its funding request and the total funding amount approved by USAC comply with applicable law and the FCC's requirements, but that the arbitrarily created category of "Committed Funding" based upon a pro rata formula is contrary to applicable law and policy. Therefore, Maniilaq respectfully requests that the RHC Division reverse its decision and issue full funding for these funding requests.

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GCI 143001199	Maniilaq Medical Center 10810	43147160	16892841	$1,256,040.00	$1,162,189.19	$93,850.81
GCI 143001199	Maniilaq Medical Center 10810	43147160	16904171	$313,965.00	$290,505.66	$23,459.34
GCI 143001199	Buckland Clinic 10812	43159666	16898961	$394,169.52	$364,717.33	$29,452.19
GCI 143001199	Noorvik Clinic 10817	43159646	16899001	$376,116.43	$348,013.16	$28,103.27
GCI 143001199	Selawik Clinic 10819	43159671	16899031	$385,142.98	$356,365.25	$28,777.73
					Total:	**$203,643.34**

Maniilaq is not merely an interest group, community health program, or loose assemblage of health care providers in rural Alaska. Maniilaq is a regional organization formed by sovereign Alaska Native nations, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by Maniilaq is not simply a goal to hopefully be obtained but is rather a part of the federal trust responsibility to tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what has become known as "federal Indian law," including the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.*

The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" took different forms and doctrines. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care with the Indian Health Care Improvement Act, where the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to tribes and Alaska Native villages that the FCC's approach to rural health care must be understood. The FCC took up the matter of its own relationship with tribes/Alaska Natives in June 2000 with its Policy Statement "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes." In that Policy Statement, the FCC

states that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

Among other ways that the FCC has specifically committed itself to implementing the trust responsibility, the FCC states that it will "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives ...that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* In addition, the FCC "[w]ill endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

Maniilaq has entered into multiple agreements with the federal government under the Indian Self-Determination and Education Assistance Act (ISDEAA) in order to contract/compact for funding to carry out health care programs, functions, services and activities. Health care is one such area where Maniilaq, and its member tribes and villages, fundamentally rely upon RHC funding through the USAC to carry out federal programs and the federal trust responsibilities. Therefore, Maniilaq relies upon the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between Maniilaq and the United States.

Section 254(h)(1)(A) of the Telecommunications Act is written unambiguously as a mandatory program that includes funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress instructed the FCC to make payments to telecommunications providers on behalf of rural health care providers and a "[t]elecommunications carrier providing service under this paragraph **shall be entitled** to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its **obligation** to participate in the mechanisms to preserve and advance universal service." (emphasis added) 47 U.S.C. § 254(h)(1)(A). Like the federal trust responsibility, these payments by the FCC, through the USAC, are mandatory, not optional. The FCC and the USAC may not ignore the mandatory language of the statute by invoking a non-statutory cap on payments.[2]

[2] *Cf. Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the caps were statutory, and full payment was still required. Here, the caps are merely unpromulgated agency guidelines.

If the RHC has a question with how to interpret the meaning of "shall be entitled" and "obligation", it should note that the Commission has, in the past, interpreted other terms in question in favor of federally recognized tribes "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes" such as the Maniilaq's member tribes. *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003).

Following the passage of the Telecomm Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No. 96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, but involved the right to federal funding:

> Section 254(h)(1)(A) grants the **right to receive** federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state." *FCC Universal Service Order* at 335-36 (emphasis added).

But instead of then structuring the program at the outset as a program with mandatory funding obligations that sprang from the statute itself, the FCC made the determination to establish a $400 million cap on RHC funding. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

FCC lacked the authority, under the statute, to create this arbitrary cap. The legality of the cap has not yet been litigated because the funding within the so-called cap has, until 2016, kept pace with demand for funding. This is notwithstanding the fact that if the initial $400 million cap had been increased in pace with inflation, it should now (at a minimum) be funded at $609,405,607. Nonetheless, the FCC has kept the cap in place, despite the mandate of the statute.

Even when it established the cap, the FCC still intended the RHC to provide full funding. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a specific amount to Congress, not to require a pro rata formula for distribution. The FCC stated "[w]e estimate that the **maximum** cost of providing services eligible for support under section 254(h)(1)(A) is $366 million, if **all eligible health care providers** obtain the **maximum** amount of supported services to which they are **entitled**." *FCC Universal Service Order* at 366 (emphasis added).

Funding for broadband-enabled health care is needed today more than ever, and the $400 million cap established 20 years ago was not established consistent with the statutory language mandating full RHC funding. The USAC now administers almost $10 billion annually in the

Universal Service Fund.[3] The FCC cap, in shorting tribes and Alaska Native organizations such as Maniilaq, has violated the agency's own tribal Policy Statement as well as the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. 2016 has shown that this arbitrary cap is now not only no longer sufficient to meet burgeoning demand, but the inclusion of a new class of provider eligible to receive funding – skilled nursing facilities – beginning in 2017 will place additional demands on funding and further erode Maniilaq programs and services. Lives are truly at stake.

Conclusion

Therefore, for the foregoing reasons, Maniilaq requests that this appeal be granted and that the RHC Division commit full funding for all of the attached FCLs in the amount that is in dispute due to the pro rata formula $203,643.34.

Respectfully Submitted,

Geoffrey D. Strommer by SDO

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On behalf of
Maniilaq Association

[3] http://www.usac.org/about/default.aspx.

Letter of Appeal
Rural Health Care Division
Universal Service Administrative Company
2000 L Street, N.W., Suite 200
Washington, D.C. 20036

Appellant/Health Care Provider:	Norton Sound Health Corporation P.O. Box 966 Nome, AK 99762 Tel: 907-443-3311 HCP No. (see Table 1 below)
Service Provider Name:	GCI Communication Corp. SPIN 143001199
Form 465 Number:	(see Table 1 Below)
Funding Request Number:	(see Table 1 Below)

Dear Rural Health Care Division Staff:

Norton Sound Health Corporation (NSHC) provides health care services to Alaska Natives and other beneficiaries on behalf of 24 tribal governments pursuant to the Alaska Tribal Health Compact and funding agreements with the Secretary of Health and Human Services under the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 et seq. NSHC hereby requests review and reversal of the decision of the Rural Health Care (RHC) Division to deny funding for the above-referenced Funding Requests for services provided by GCI.[1]

NSHC believes that the RHC Division erred in concluding that it would arbitrarily apply an across-the-board pro rata reduction in funding due to the $400 million funding cap that the Federal Communications Commission (FCC) purported to impose, thus eliminating any opportunity for full funding for the services requested in its Forms 465 and Form 466. Therefore, NSHC believes that it has met all requirements of the RHC funding mechanism, and that the RHC Division should have committed funding for the Funding Requests summarized in the attached table.

Background

The NSHC Form(s) 465 referenced in the below Table 1 were submitted on behalf of NSHC for services at clinics that provide health care for NSHC member tribes' populations as well as other eligible beneficiaries.

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[1] RHC Division Funding Commitment Letters dated April 11, 2017 attached as **Exhibit A.**

On April 11, 2017, 26 Funding Commitment Letters (FCLs) were issued by USAC. In those FCLs, USAC for the first time distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The asterisk used by USAC then stated the following: "The pro-rata factor for this filing window period is 92.52804%."

USAC remitted funding to NSHC through the FCLs at the rate of 92.52804% of the amount requested, resulting in the denial of funding for the FCLs in the amount of $1,487,807.22. The application of a pro rata percentage of funding by USAC amounted to a partial denial of funding, even though the FCL is not written by USAC as a funding denial.

NSHC believes that its funding request and the total funding amount approved by USAC comply with applicable law and the FCC's requirements, but that the arbitrarily created category of "Committed Funding" based upon a pro rata formula is contrary to applicable law and policy. Therefore, NSHC respectfully requests that the RHC Division reverse its decision and issue full funding for these funding requests.

Requested and Disputed Funding

The table below lays out in detail the Service Provider, Health Care Provider, Form 465 Application Numbers, Funding Request Numbers, total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the pro rata formula.

Table 1

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI 143001199	Brevig Mission Clinic 10673	43160005	16900561	$728,100.00	$673,696.66	$54,403.34
GCI 143001199	Elim Clinic 10674	43160026	16896371	$364,050.00	$336,848.33	$27,201.67
GCI 143001199	Elim Clinic 10674	43160026	16905431	$499,110.00	$461,816.70	$37,293.30
GCI 143001199	Gambell Clinic 10675	43160024	16900581	$728,100.00	$673,696.66	$54,403.34
GCI 143001199	Golovin Clinic 10676	43160029	16896431	$364,050.00	$336,848.33	$27,201.67
GCI 143001199	Golovin Clinic 10676	43160029	16905441	$499,110.00	$461,816.70	$37,293.30

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI 143001199	Koyuk Clinic 10677	43160007	16901441	$364,050.00	$336,848.33	$27,201.67
GCI 143001199	Koyuk Clinic 10677	43160007	16905451	$499,110.00	$461,816.70	$37,293.30
GCI 143001199	St Michael Clinic 10678	43160025	16896451	$364,050.00	$336,848.33	$27,201.67
GCI 143001199	St Michael Clinic 10678	43160025	16905461	$499,110.00	$461,816.70	$37,293.30
GCI 143001199	Savoonga Clinic 10679	43160008	16900621	$728,100.00	$673,696.66	$54,403.34
GCI 143001199	Shaktoolik Clinic 10680	43152852	16896471	$68,923.42	$63,773.49	$5,149.93
GCI 143001199	Shaktoolik Clinic 10680	43160027	16903731	$885,517.63	$819,352.11	$66,165.52
GCI 143001199	Katherine Miksruaq Olanna Health Clinic (Shishmaref) 10681	43160028	16900641	$728,100.00	$673,696.66	$54,403.34
GCI 143001199	Stebbins Clinic 10682	43160003	16900651	$364,050.00	$336,848.33	$27,201.67
GCI 143001199	Stebbins Clinic 10682	43160003	16905471	$499,110.00	$461,816.70	$37,293.30
GCI 143001199	Teller Clinic 10683	43160006	16900711	$728,100.00	$673,696.66	$54,403.34
GCI 143001199	Euksavik Clinic 10684	43160032	16896511	$754,920.00	$698,512.68	$56,407.32
GCI 143001199	Euksavik Clinic 10684	43160032	16903871	$241,200.00	$223,177.63	$18,022.37
GCI 143001199	Wales Clinic 10685	43160031	16900861	$728,100.00	$673,696.66	$54,403.34
GCI 143001199	White Mountain Clinic 10686	43160004	16900911	$364,050.00	$336,848.33	$27,201.67

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI 143001199	White Mountain Clinic 10686	43160004	16905481	$499,110.00	$461,816.70	$37,293.30
GCI 143001199	Little Diomede Clinic 11368	43152883	16896541	$39,753.35	$36,783.00	$2,970.35
GCI 143001199	Little Diomede Clinic 11368	43160030	16903791	$378,639.18	$350,347.41	$28,291.77
GCI 143001199	Norton Sound Health Corporation East Campus 31287	43160023	16896641	$6,051,840.00	$5,599,648.94	$452,191.06
GCI 143001199	Norton Sound Health Corporation East Campus 31287	43160023	16896681	$1,943,520.00	$1,798,300.96	$145,219.04
					Total:	**$1,487,807.22**

Discussion

The NSHC is not merely an interest group, community health program, or loose assemblage of health care providers in rural Alaska. NSHC is a regional organization formed by sovereign Alaska Native nations, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by NSHC in the Bering Strait region is not simply a goal to hopefully be obtained but is rather a part of the federal trust responsibility to tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what has become known as "federal

Indian law," including the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.*

The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" took different forms and doctrines. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care with the Indian Health Care Improvement Act, where the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to tribes and Alaska Native villages that the FCC's approach to rural health care must be understood. The FCC took up the matter of its own relationship with tribes/Alaska Natives in June 2000 with its Policy Statement "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes." In that Policy Statement, the FCC states that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

Among other ways that the FCC has specifically committed itself to implementing the trust responsibility, the FCC states that it will "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives ...that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to

implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* In addition, the FCC "[w]ill endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

The NSHC has entered into multiple agreements with the federal government under the Indian Self-Determination and Education Assistance Act (ISDEAA) in order to contract/compact for funding to carry out health care programs, functions, services and activities. Health care is one such area where NSHC, and its member tribes and villages, fundamentally rely upon RHC funding through the USAC to carry out federal programs and the federal trust responsibilities. Therefore, NSHC relies upon the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between NSHC and the United States.

Section 254(h)(1)(A) of the Telecommunications Act is written unambiguously as a mandatory program that includes funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress instructed the FCC to make payments to telecommunications providers on behalf of rural health care providers and a "[t]elecommunications carrier providing service under this paragraph **shall be entitled** to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its **obligation** to participate in the mechanisms to preserve and advance universal service." (emphasis added) 47 U.S.C. § 254(h)(1)(A). Like the federal trust responsibility, these payments by the FCC, through the USAC, are mandatory, not optional. The FCC and the USAC may not ignore the mandatory language of the statute by invoking a non-statutory cap on payments.[2]

If the RHC has a question with how to interpret the meaning of "shall be entitled" and "obligation", it should note that the Commission has, in the past, interpreted other terms in question in favor of federally recognized tribes "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes" such as the NSHC's member tribes. *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003).

Following the passage of the Telecomm Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No.

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[2] *Cf. Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the caps were statutory, and full payment was still required. Here, the caps are merely unpromulgated agency guidelines.

96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, but involved the right to federal funding:

> Section 254(h)(1)(A) grants the **right to receive** federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state." *FCC Universal Service Order* at 335-36 (emphasis added).

But instead of then structuring the program at the outset as a program with mandatory funding obligations that sprang from the statute itself, the FCC made the determination to establish a $400 million cap on RHC funding. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

FCC lacked the authority, under the statute, to create this arbitrary cap. The legality of the cap has not yet been litigated because the funding within the so-called cap has, until 2016, kept pace with demand for funding. This is notwithstanding the fact that if the initial $400 million cap had been increased in pace with inflation, it should now (at a minimum) be funded at $609,405,607. Nonetheless, the FCC has kept the cap in place, despite the mandate of the statute.

Even when it established the cap, the FCC still intended the RHC to provide full funding. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a specific amount to Congress, not to require a pro rata formula for distribution. The FCC stated "[w]e estimate that the **maximum** cost of providing services eligible for support under section 254(h)(1)(A) is $366 million, if **all eligible health care providers** obtain the **maximum** amount of supported services to which they are **entitled**." *FCC Universal Service Order* at 366 (emphasis added).

Funding for broadband-enabled health care is needed today more than ever, and the $400 million cap established 20 years ago was not established consistent with the statutory language mandating full RHC funding. The USAC now administers almost $10 billion annually in the Universal Service Fund.[3] The FCC cap, in shorting tribes and Alaska Native organizations such as NSHC, has violated the agency's own tribal Policy Statement as well as the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. 2016 has shown that this arbitrary cap is now not only no longer sufficient to meet burgeoning demand, but the inclusion of a new class of provider eligible to receive funding – skilled nursing facilities – beginning in 2017 will place additional demands on funding and further erode NSHC programs and services. Lives are truly at stake.

[3] http://www.usac.org/about/default.aspx.

Conclusion

Therefore, for the foregoing reasons, NSHC requests that this appeal be granted and that the RHC Division commit full funding for all of the attached FCLs in the amount that is in dispute due to the pro rata formula $1,487,807.22.

Respectfully Submitted,

Geoffrey D. Strommer by SDO

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On behalf of
Norton Sound Health Corporation

Letter of Appeal
Rural Health Care Division
Universal Service Administrative Company
2000 L Street, N.W., Suite 200
Washington, D.C. 20036

Appellant/Health Care Provider:	Aleutian Pribilof Islands Association 1131 E. International Airport Rd. Anchorage, AK 99518-1408 Tel: 907-276-2700 HCP No. (see Table 1 below)
Service Provider Name:	GCI Communication Corp.; Alascom SPIN: 143001199, 143005617
Form 465 Number:	(see Table 1 Below)
Funding Request Number:	(see Table 1 Below)

Dear Rural Health Care Division Staff:

The Aleutian Pribilof Islands Association (APIA) is a regional inter-tribal consortium that provides health care services to Alaska Natives and other beneficiaries on behalf of 11 federally recognized tribal governments pursuant to the Alaska Tribal Health Compact and funding agreements with the Secretary of Health and Human Services under the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 et seq. APIA hereby requests review and reversal of the decision of the Rural Health Care (RHC) Division to deny funding for the above-referenced Funding Requests for services provided by GCI.[1]

APIA believes that the RHC Division erred in concluding that it would arbitrarily apply an across-the-board pro rata reduction in funding due to the $400 million funding cap that the Federal Communications Commission (FCC) purported to impose, thus eliminating any opportunity for full funding for the services requested in its Forms 465 and Form 466. Therefore, APIA believes that it has met all requirements of the RHC funding mechanism, and that the RHC Division should have committed funding for the Funding Requests summarized in the attached table.

Background

The APIA Form(s) 465 referenced in the below Table 1 were submitted on behalf of APIA for services at clinics that provide health care for APIA member tribes' populations as well as other eligible beneficiaries.

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[1] RHC Division Funding Commitment Letters dated April 11, 2017 attached as **Exhibit A.**

On April 11, 2017, 16 Funding Commitment Letters (FCLs) were issued by USAC. In those FCLs, USAC for the first time distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The asterisk used by USAC then stated the following: "The pro-rata factor for this filing window period is 92.52804%."

USAC remitted funding to APIA through the FCLs at the rate of 92.52804% of the amount requested, resulting in the denial of funding for the FCLs in the amount of $152,027.24. The application of a pro rata percentage of funding by USAC amounted to a partial denial of funding, even though the FCL is not written by USAC as a funding denial.

APIA believes that its funding request and the total funding amount approved by USAC comply with applicable law and the FCC's requirements, but that the arbitrarily created category of "Committed Funding" based upon a pro rata formula is contrary to applicable law and policy. Therefore, APIA respectfully requests that the RHC Division reverse its decision and issue full funding for these funding requests.

Requested and Disputed Funding

The table below lays out in detail the Service Provider, Health Care Provider, Form 465 Application Numbers, Funding Request Numbers, total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the pro rata formula.

Table 1

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
Alascom, 143005617	Atka Clinic 10759	43163914	16879521	$74,744.88	$69,159.97	$5,584.91
GCI 143001199	Atka Clinic 10759	43163914	16946641	$48,221.28	$44,618.21	$3,603.07
GCI 143001199	Atka Clinic 10759	43163914	16946651	$282,100.00	$261,021.60	$21,078.40
GCI 143001199	Atka Clinic 10759	43163914	16946661	$95,522.00	$88,384.63	$7,137.37
Alascom, 143005617	Nikolski Clinic 10760	43163915	16929511	$74,843.04	$69,250.80	$5,592.24
GCI 143001199	Nikolski Clinic 10760	43163915	16946631	$48,221.28	$44,618.21	$3,603.07
GCI 143001199	Nikolski Clinic 10760	43163915	16946681	$282,100.00	$261,021.60	$21,078.40
GCI 143001199	Nikolski Clinic 10760	43163915	16946691	$95,522.00	$88,384.63	$7,137.37
Alascom, 143005617	Oonalaska Wellness Center 10762	43163785	16929801	$77,095.68	$71,335.12	$5,760.56
GCI 143001199	Oonalaska Wellness Center 10762	43163785	16946571	$50,133.24	$46,387.30	$3,745.94
GCI	Oonalaska	43163785	16946701	$303,128.00	$280,478.40	$22,649.60

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
143001199	Wellness Center 10762					
GCI 143001199	Oonalaska Wellness Center 10762	43163785	16946721	$100,212.00	$92,724.20	$7,487.80
Alascom, 143005617	St. George Traditional Clinic 11608	43163913	16884831	$74,744.88	$69,159.97	$5,584.91
GCI 143001199	St. George Traditional Clinic 11608	43163913	16946611	$48,221.28	$44,618.21	$3,603.07
GCI 143001199	St. George Traditional Clinic 11608	43163913	16946731	$284,305.00	$263,061.84	$21,243.16
GCI 143001199	St. George Traditional Clinic 11608	43163913	16946741	$95,522.00	$88,384.63	$7,137.37
					Total:	**$152,027.24**

Discussion

The APIA is not merely an interest group, community health program, or loose assemblage of health care providers in rural Alaska. APIA is a regional organization formed by sovereign Alaska Native nations, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by APIA is not simply a goal to hopefully be obtained but is rather a part of the federal trust responsibility to tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what has become known as "federal Indian law," including the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.*

The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" took different forms and doctrines. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization

supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health … [and] for the employment of … physicians … for Indian tribes." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care with the Indian Health Care Improvement Act, where the federal government found that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

It is against this backdrop of the federal trust responsibility to provide health care services to tribes and Alaska Native villages that the FCC's approach to rural health care must be understood. The FCC took up the matter of its own relationship with tribes/Alaska Natives in June 2000 with its Policy Statement "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes." In that Policy Statement, the FCC states that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

Among other ways that the FCC has specifically committed itself to implementing the trust responsibility, the FCC states that it will "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives …that Indian Tribes have adequate access to communications services." *Id.* at 4. The FCC also, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* In addition, the FCC "[w]ill endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

The APIA has entered into multiple agreements with the federal government under the Indian Self-Determination and Education Assistance Act (ISDEAA) in order to contract/compact for funding to carry out health care programs, functions, services and activities. Health care is one such area where APIA, and its member tribes and villages, fundamentally rely upon RHC funding through the USAC to carry out federal programs and the federal trust responsibilities. Therefore, APIA relies upon the FCC to implement federal law and regulations related to RHC funding and implementation in a manner that is supportive of the trust responsibility as well as the contractual obligations between APIA and the United States.

Section 254(h)(1)(A) of the Telecommunications Act is written unambiguously as a mandatory program that includes funding as an entitlement associated with that mandate. Under Section 254(h)(1)(A), Congress instructed the FCC to make payments to telecommunications providers on behalf of rural health care providers and a "[t]elecommunications carrier providing service under this paragraph **shall be entitled** to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its **obligation** to participate in the mechanisms to preserve and advance universal service." (emphasis added) 47 U.S.C. § 254(h)(1)(A). Like the federal trust responsibility, these payments by the FCC, through the USAC, are mandatory, not optional. The FCC and the USAC may not ignore the mandatory language of the statute by invoking a non-statutory cap on payments.[2]

If the RHC has a question with how to interpret the meaning of "shall be entitled" and "obligation", it should note that the Commission has, in the past, interpreted other terms in question in favor of federally recognized tribes "[i]n light of the goal of the rural health care universal service provision...and consistent with the federal trust relationship between the federal government and federally-recognized Indian tribes" such as the APIA's member tribes. *FCC Order in the Matter of Requests for Review of the Decisions of the Universal Service Administrator by Kawerak, et. al.*, 18 FCC Rcd. 18767 (2003).

Following the passage of the Telecomm Act in 1997, and during the implementation phase of the RHC funding, the FCC issued a Report and Order "In the Matter of Federal-State Joint Board on Universal Service" (hereafter "*FCC Universal Service Order*"), FCC Docket No. 96-45 (May 8, 1997). In the Order, the FCC agreed that the RHC funding was not a discretionary grant program, but involved the right to federal funding:

> Section 254(h)(1)(A) grants the **right to receive** federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state." *FCC Universal Service Order* at 335-36 (emphasis added).

But instead of then structuring the program at the outset as a program with mandatory funding obligations that sprang from the statute itself, the FCC made the determination to establish a $400 million cap on RHC funding. It did so not because it was directed to by Congress, or because the initial Joint Board suggested a cap, but instead to "be specific, predictable, and sufficient." *FCC Universal Service Order* at 365.

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[2] *Cf. Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012) (statute requires full payment of tribal organization's "contract support costs" despite spending caps). In *Ramah*, the caps were statutory, and full payment was still required. Here, the caps are merely unpromulgated agency guidelines.

FCC lacked the authority, under the statute, to create this arbitrary cap. The legality of the cap has not yet been litigated because the funding within the so-called cap has, until 2016, kept pace with demand for funding. This is notwithstanding the fact that if the initial $400 million cap had been increased in pace with inflation, it should now (at a minimum) be funded at $609,405,607. Nonetheless, the FCC has kept the cap in place, despite the mandate of the statute.

Even when it established the cap, the FCC still intended the RHC to provide full funding. In the FCC Universal Service Order, the FCC found that the cap was only intended to provide a specific amount to Congress, not to require a pro rata formula for distribution. The FCC stated "[w]e estimate that the **maximum** cost of providing services eligible for support under section 254(h)(1)(A) is $366 million, if **all eligible health care providers** obtain the **maximum** amount of supported services to which they are **entitled**." *FCC Universal Service Order* at 366 (emphasis added).

Funding for broadband-enabled health care is needed today more than ever, and the $400 million cap established 20 years ago was not established consistent with the statutory language mandating full RHC funding. The USAC now administers almost $10 billion annually in the Universal Service Fund.[3] The FCC cap, in shorting tribes and Alaska Native organizations such as APIA, has violated the agency's own tribal Policy Statement as well as the trust responsibility of the federal government to provide health care to American Indians/Alaska Natives. 2016 has shown that this arbitrary cap is now not only no longer sufficient to meet burgeoning demand, but the inclusion of a new class of provider eligible to receive funding – skilled nursing facilities – beginning in 2017 will place additional demands on funding and further erode APIA programs and services. Lives are truly at stake.

Conclusion

Therefore, for the foregoing reasons, APIA requests that this appeal be granted and that the RHC Division commit full funding for all of the attached FCLs in the amount that is in dispute due to the pro rata formula $152,027.24

Respectfully Submitted,

/s/ Geoffrey D. Strommer

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On behalf of
Aleutian Pribilof Islands Association

Letter of Appeal
Rural Health Care Division
Universal Service Administrative Company
2000 L Street, N.W., Suite 200
Washington, D.C. 20036

Appellant/Health Care Provider:	Council of Athabascan Tribal Governments P.O. Box 33 Fort Yukon, AK 99740 Tel: 907-662-2587 HCP No. (see Table 1 below)
Service Provider Name:	GCI Communication Corp. SPIN: 143001199
Form 465 Number:	(see Table 1 Below)
Funding Request Number:	(see Table 1 Below)

Dear Rural Health Care Division Staff:

The Council of Athabascan Tribal Governments (CATG) is a tribal consortium representing ten Gwich'in and Koyukon Athabascan villages in the Yukon Flats region of Alaska. CATG provides health care services to Alaska Natives and other beneficiaries on behalf of ten federally recognized tribal governments pursuant to the Alaska Tribal Health Compact and funding agreements with the Secretary of Health and Human Services under the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 et seq. CATG hereby requests review and reversal of the decision of the Rural Health Care (RHC) Division to deny funding for the above-referenced Funding Requests for services provided by GCI.[1]

CATG believes that the RHC Division erred in concluding that it would arbitrarily apply an across-the-board pro rata reduction in funding due to the $400 million funding cap that the Federal Communications Commission (FCC) purported to impose, thus eliminating any opportunity for full funding for the services requested in its Forms 465 and Form 466. Therefore, CATG believes that it has met all requirements of the RHC funding mechanism, and that the RHC Division should have committed funding for the Funding Requests summarized in the attached table.

Background

The CATG Form(s) 465 referenced in the below Table 1 were submitted on behalf of CATG for services at clinics that provide health care for CATG member tribes' populations as well as other eligible beneficiaries.

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[1] RHC Division Funding Commitment Letters dated April 11, 2017 attached as **Exhibit A.**

On April 11, 2017, a Funding Commitment Letter (FCL) was issued by USAC. In this FCL, USAC for the first time distinguished between the "Total Funding Amount" and the "Committed Funding Amount*". The asterisk used by USAC then stated the following: "The pro-rata factor for this filing window period is 92.52804%."

USAC remitted funding to CATG through the FCL at the rate of 92.52804% of the amount requested, resulting in the denial of funding for the FCL in the amount of $8,434.74. The application of a pro rata percentage of funding by USAC amounted to a partial denial of funding, even though the FCL is not written by USAC as a funding denial.

CATG believes that its funding request and the total funding amount approved by USAC comply with applicable law and the FCC's requirements, but that the arbitrarily created category of "Committed Funding" based upon a pro rata formula is contrary to applicable law and policy. Therefore, CATG respectfully requests that the RHC Division reverse its decision and issue full funding for these funding requests.

Requested and Disputed Funding

The table below lays out in detail the Service Provider, Health Care Provider, Form 465 Application Numbers, Funding Request Numbers, total funding requested and approved by USAC, as well as the total "Committed Funding Amount" by USAC, which reflects the application of the pro rata formula.

Table 1

Service Provider and SPIN Number	Health Care Provider (HCP) and HCP Number	Form 465 Application Number	Funding Request Number (FRN)	Total Funding Amount	Committed Funding Amount from USAC	Amount in Dispute Due to Pro Rata Distribution
GCI 143001199	Arctic Village Clinic 11018	43125521	16902011	$112,885.20	$104,450.46	$8,434.74

Discussion

The CATG is not merely an interest group, community health program, or loose assemblage of health care providers in rural Alaska. CATG is a regional organization formed by sovereign Alaska Native nations, each of which is federally recognized by the United States Department of the Interior. As such, the provision of health care by CATG is not simply a goal to hopefully be obtained but is rather a part of the federal trust responsibility to tribes, Alaska Native villages, and their members.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what has become known as "federal

Indian law," including the relationship of sovereign tribal nations to the federal government. In *Cherokee Nation v. Georgia*, Chief Justice Marshall noted the special duty the federal government assumed in its dealings and agreements with American Indians. *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831). Marshall identified Indian Tribes as "domestic dependent nations" and observed that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Id.*

The following year, the Supreme Court in *Worchester v. Georgia* established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian Tribes. *Worcester v. Georgia*, 31 U.S. 515 (1832).

As the relationship with tribes and Alaska Natives moved into the twentieth century, this broad concept of the federal "trust responsibility" took different forms and doctrines. In the area of healthcare, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health ... [and] for the employment of ... physicians ... for Indian tribes." 25 U.S.C. § 13.

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[3] http://www.usac.org/about/default.aspx.

Conclusion

Therefore, for the foregoing reasons, CATG requests that this appeal be granted and that the RHC Division commit full funding for all of the attached FCLs in the amount that is in dispute due to the pro rata formula $8,434.74.

Respectfully Submitted,

Geoffrey D. Strommer by SDO

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On behalf of
Council of Athabascan Tribal Governments